DENTAL INSURANCE ENROLLMENT FORM
CITY OF MILWAUKEE

A SELECT A DENTAL PLAN			Desired Coverage	
Delta PPO ☐	Delta EPO ☐	Careplus ☐	Single ☐	Family ☐

B YOUR LAST NAME	FIRST NAME	M.I.	GENDER	DATE OF BIRTH
			M ☐ F ☐	/ /

HOME ADDRESS	APT. #	CITY	STATE	ZIP CODE

TELEPHONE NUMBER	6 DIGIT EMPLOYEE ID (Must be Indicated)	MARITAL STATUS
		☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

CITY START DATE	RETURN TO WORK DATE	JOB TITLE	DEPARTMENT

C FAMILY COVERAGE ---- LIST ALL INDIVIDUALS TO BE INCLUDED

LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH m m / d d / y y	RELATIONSHIP: Spouse / Dependent / Domestic Partner / Adult Child / Other-- please indicate relationship
		M ☐ F ☐	/ /	
		M ☐ F ☐	/ /	
		M ☐ F ☐	/ /	
		M ☐ F ☐	/ /	
		M ☐ F ☐	/ /	
		M ☐ F ☐	/ /	
		M ☐ F ☐	/ /	

D REASON FOR SUBMITTING ENROLLMENT FORM:

☐ INITIAL ENROLLMENT	☐ ADD DEPENDENT	☐ DELETE SPOUSE	Name:	DATE / /
☐ OPEN ENROLLMENT	☐ FAMILY TO SINGLE	☐ DELETE DEPENDENT	Name:	DATE / /
☐ RETURN TO WORK	☐ SINGLE TO FAMILY	☐ DEATH	Name:	DATE / /
☐ OTHER ____		☐ MARRIAGE (PROVIDE DATE)	Maiden Name:	DATE / /
☐ NAME CHANGE From:____ To: ____		☐ DIVORCE (PROVIDE DATE)	Name:	DATE / /

E IS ANYONE NAMED ON THIS ENROLLMENT FORM COVERED BY ANOTHER GROUP DENTAL INSURANCE PLAN? ☐ YES ☐ NO

IF YES:

NAME OF POLICYHOLDER (Usually your Spouse or Parent) _____

POLICYHOLDER'S EMPLOYER _____

NAME OF INSURANCE COMPANY _____

POLICYHOLDER'S IDENTIFICATION NUMBER _____

F Is Anyone Named On This Enrollment Form Disabled, Mentally Incompetent Or Unable To Perform Normal Work Or Age-Related Activities?

YES ☐ NO ☐ If Yes, please indicate name: _____

I apply for enrollment under the terms and conditions of my employer's Health Plan as administered by the entity stated in Section A and subject to the coverage rules and conditions on the reverse side. I understand that coverage is not effective until I have satisfied the health plan coverage eligibility criteria and rules. I authorize any payroll/pension deductions that may be necessary to cover the cost of my plan. To the best of my knowledge, all statements and answers in this application are complete and true and that any misrepresentation of coverage in this application may result in loss or denial of coverage for me and my dependents.

X _____ / /

YOUR SIGNATURE _____ DATE SIGNED _____

FOR OFFICE USE ONLY

GROUP NUMBER	SECTION NUMBER	EMPLOYEE ID	UNION AFFILIATION

EFFECTIVE DATE	PAYROLL ADJUSTMENT DATA

Active Employees: Return completed form to Employee Benefits **Retirees:** Return completed form to Employe's Retirement System. 9/28/17

Terms and Conditions

- To the best of my knowledge, all statements and answers on this enrollment form are complete and true and any misrepresentation of coverage in this application may result in loss or denial of coverage for me and my dependents.
- I authorize the City of Milwaukee to deduct from my wages, salary, or pension an amount sufficient to provide for regular dental premium payments that are not otherwise contributed by the City.
- I acknowledge that children listed on this enrollment form identified as "dependent" are under age 26 and eligible for coverage as measured by standards employed by the IRS for determining dependency. Any child listed as a dependent who is over the age of 26 must be disabled so as to be incapable of self-support in order to remain eligible for coverage.

Notice to Members Regarding the Thirty-One Day Rule for Health and Dental Plan Coverage

City of Milwaukee employees and retirees are responsible for keeping their enrollment status current and notifying the DER Employee Benefits Division or the Employes' Retirement System (ERS) within 31 days of births, adoptions, marriages (including marriage to another City employee), divorces, changes in dependent eligibility status, deaths and Medicare coverage. Coverage for dependents is effective the date of the family status change provided members notify DER or ERS within 31 days of the event. Members must submit a copy of the marriage certificate, birth certificate and include social security numbers for each dependent enrolling in benefits. Non-compliance with coverage eligibility rules may expose members to additional costs or result in removal of dependents from the plan. There are no exceptions to this rule.

Enrollment Status and Changes

- City employees must use the City's Self Service program www.milwaukee.gov/selfservice to make changes or updates to their enrollment status including address changes, births, adoptions and marriages. Employees must have their Employee ID number (6 digits) and a password to access self service. To request or reset a password visit www.milwaukee.gov/rits.
- City employees must fill out a paper enrollment form for any other status changes, such as divorce or removal of dependents.
- City employees returning to work must complete a health and dental enrollment form within 31 days of their return to work date.
- Agency employees must complete a health and dental enrollment form within 31 days of their start date and notify the appropriate agency of any other enrollment status changes within 31 days of the event.
- Retirees are responsible for keeping their enrollment status, including births, marriages, Medicare entitlement and other family status changes current by contacting ERS and completing the proper waiver or enrollment forms.

Compliance Notifications

Important legal notices, including HIPPA notice of privacy practices, affecting employee and retiree health plans are posted on DER's benefits website www.milwaukee.gov/Benefits2018 under "L" Legal Notices.